APPEAL NO. 93378

On February 18, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding as the hearing officer. The hearing was held under the provisions of the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-1.01 *et seq*. (Vernon Supp. 1993) (1989 Act). The hearing officer determined that the claimant reached maximum medical improvement (MMI) on March 13, 1992, with an impairment rating of zero percent as reported by the designated doctor. The appellant (claimant herein) disagrees with the hearing officer's findings and conclusions concerning MMI and impairment rating for various reasons and contends that the hearing officer erred in other respects. The respondent (carrier herein) responds that the hearing officer's decision is supported by the evidence.

DECISION

The decision of the hearing officer is affirmed.

The unresolved issue from the benefit review conference (BRC) was "Are temporary income benefits owed to [the claimant] given MMI certification and 0% impairment by Dr. Q (required medical exam doctor) and Dr. S (designated doctor)?" The parties stipulated at the hearing that the claimant sustained a work-related injury and had been paid temporary income benefits (TIBS) until TIBS were suspended by interlocutory order on November 13, 1992. Although the stipulation was not recited in the decision, we do not find that omission to be error as asserted by the claimant in view of the fact that in the Statement of the Evidence portion of the decision the hearing officer states that the claimant sustained a work-related injury while working for the employer.

The claimant, who is 25 years of age, injured her back when she slipped and fell at work on (date of injury). (Dr. R) has been her treating doctor.

On October 17, 1991, Dr. R diagnosed: 1) lumbosacral spine strain, 2) thoracic spine contusion, and 3) right lumbar radiculopathy. Dr. R referred the claimant to (Dr. L) for an EMG of her lower back and both lower extremities. On October 29, 1991, Dr. L reported the results of the EMG as follows:

> Needle EMG was completely normal showing no evidence for "denervation phenomena" in any of the lumbosacral myotomes. We therefore were a little surprised to find we could not obtain H-reflexes. The conduction velocities of her nerves seem to be within normal limits and there was no temporal dispersion of the evoked potentials. Generally, when an H-reflex is blocked it is either an S1 radiculopathy or a polyneuropathic process.
>
> When I cannot obtain H-reflexes despite normal velocities and appearance of CMAP's and normal needle EMG measurements, I would consider them to be of doubtful clinical significance.

No abnormalities were demonstrated in a CT scan of the claimant's lumbar spine done on October 29, 1991. The claimant testified that she was examined by (Dr. Q) at the request of the carrier. Dr. Q's Report of Medical Evaluation (TWCC-69) and narrative report of March 13, 1992, were excluded from evidence for failure to timely exchange them with the claimant. No complaint of that evidentiary ruling has been made on appeal.

A report of the results of an MRI of the claimant's lumbar spine done on April 13, 1992, showed no abnormalities at the L1-2, L2-3, and L3-4 levels. However, "minimal disc degeneration" was shown at the L4-5 level and "mild disc degeneration" was shown at the L5-S1 level. The radiologist noted that the MRI demonstrated no lumbar disc herniation.

In a TWCC-69 which has the date "5/23/92" written at the top, Dr. R reported that the claimant had not reached MMI and that the estimated date of MMI was undetermined. In addition to reporting the results of the April 1992 MRI, Dr. R reported that a lumbar myelogram done on February 28, 1992, showed a minimal focal protrusion at L4-5. Although Dr. R did not give a whole body impairment rating in Section 14 of the report, which was appropriate since he had not found MMI, he wrote in Section 15 of the report which calls for the listing of body parts/system and rating, "lumbar spine 15%." In a note dated June 4, 1992, Dr. R stated that he had examined the claimant on May 29, 1992, and had reviewed Dr. Q's evaluation report of March 13, 1992. Dr. R said "[i]t is still my opinion that this lady has 15% permanent partial disability of the lumbar spine." In a note dated August 13, 1992, Dr. R said he had seen the claimant several more times, that she had positive neurological signs, and that he had recommended a lumbar discogram.

Dr. S, a radiologist, performed the discogram on August 24, 1992, and interpreted the results as follows:

L3-4: Normal no pain at the time of injection.

L4-5: Mild degeneration. No herniation. Mild back pain at the time of injection.

L5-S1: Degenerated disc with herniation posteriorly on the right side. The patient exhibited sharp back and right leg pain at the exact time of injection.

Also on August 24, 1992, after the discogram was done, a CT scan of the claimant's lumbar spine was performed by Dr. G., a radiologist, who interpreted the results of the CT scan as follows:

L3-4: No evidence of herniation. Lateral recesses are intact. No extravasation of contrast.

L4-5:Mild facet hypertrophy is present. No extravasation of contrast or evidence of herniation.

L5-S1: No evidence of contrast extravasation or herniation.

In a note dated September 1, 1992, Dr. R stated that the discogram of August 24th showed a "ruptured, degenerated disk at L5-S1," and that in view of the positive findings of the discogram he was recommending laminectomy and discectomy at the L5-S1 level. The carrier requested a second opinion on spinal surgery, and, according to the parties, the claimant was seen by (Dr. G) for a second opinion on October 12, 1992. Dr. G examined the claimant and reviewed her test results, including the discogram. He stated that he felt that the claimant's clinical symptoms are consistent with an underlying "L5-S1 HNP." He also said that he had a long discussion with the claimant concerning treatment options, that he did not feel she would be appreciably improved with surgical intervention at this point, that the claimant related that she is not desirous of any surgery, and that he recommended consideration of a trial of epidural steroid injections at the L5-S1 level. Dr. G said that in his opinion the claimant "has reached maximum medical improvement with conservative treatment." He also stated that the claimant "should be considered to have a 7% total body impairment relative to her L5-S1 symptomatic disc herniation." Dr. G further stated that the claimant indicated that she would consider the injections, and that he had not recommended any surgical intervention. In a TWCC-69 dated October 30, 1992, Dr. G certified that the claimant reached MMI on October 12, 1992, with a seven percent whole body impairment rating.

The claimant testified that the Texas Workers' Compensation Commission (Commission) sent her to (Dr. SC). Although the record does not contain an order from the Commission selecting Dr. SC as the designated doctor, he is identified as such three times in the disputed issue form attached to the BRC report, and the issue as framed by the hearing officer and agreed to by the parties at the hearing also identified Dr. SC as the designated doctor. According to a four page narrative report dated October 15, 1992, Dr. SC examined the claimant on that date and reviewed her medical records and test results. Among other things he noted that Dr. Q's examination of the claimant in March 1992 revealed no objective findings to substantiate her continued subjective complaints and that Dr. Q had felt that the claimant could return to full duty without limitation and that she had no permanent disability. In regard to the August 24, 1992, discogram, Dr. SC stated:

As noted performance of a discogram is a rather controversial study and there is question as concerns the validity of the findings. I do not feel that this study

offers any further information than was obtained by the CAT scan, EMG, MRI, but most important the cinical (sic) findings in this patient.

Dr. SC further stated that:

As noted by [Dr. Q] there was no objective findings to substantiate this patients (sic) cntinued (sic) subjective complaints. I performed a detailed orthopedic and neurological examination and also I could find no definite objective findings to substantiate this patients (sic) continued subjective complaints. The finding of numbness over the entire right half of this patients (sic) body except her skull, certainly would indicate a psycho-social functional etiology to her symptomatology. If an individual has symptomatology of an incapacitating nature for more than a year as is evident in this individual, certainly objective findings would be present to substantiate these persistent recalcitrant symptoms. I certainly cannot justify the recommendation for a lumbar laminectomy on the basis of a controversial diagnostic study such as a discogram in an individual who has no objective findings on physical examination and who's other diagnostic studies are entirely within normal limits, except for degeneration of the L4-5 and or L5-S1 disc which does not produce and is not consistent with this patients (sic) subjective complaints, especially the radiation of pain in the right lower extremity, numbness, etc.

Dr. SC noted that when he questioned the claimant concerning the surgery recommended by Dr. R, the claimant told him that she did not wish to have surgery performed. Dr. SC stated that he does not feel that surgical intervention is indicated in this case. He also said that further diagnostic studies and treatment are not indicated. He said he agreed with Dr. Q that there was no objective evidence to substantiate the claimant's subjective complaints and that there was no evidence of permanent impairment. He also stated "I feel that she has already reached maximum medical improvement." In a TWCC-69 dated October 15, 1992, Dr. SC certified that the claimant reached MMI on March 13, 1992, with a zero percent whole body impairment rating.

In a letter dated January 5, 1993, Dr. G responded to the claimant's request for clarification concerning his certification of MMI of October 12, 1992 by stating:

As noted, [the claimant] is symptomatic from an underlying L5-S1 HNP. Treatment options were discussed in detail with [the claimant]. She indicated no desire to proceed with surgical intervention. Similarly, I felt that surgical intervention would not appreciably improve her overall condition. Epidural steroid injections were mentioned as a possible treatment option. She otherwise has reached a level of maximal clinical improvement where no further medical treatment will appreciably improve her current clinical condition. Surgical

intervention as mentioned was not a viable option at this point. Therefore, she is maximally improved as no further material recovery or lasting improvement can be reasonably anticipated.

On January 8, 1993, Dr. L responded to the claimant's letter to him concerning his EMG findings of October 29, 1991. As previously mentioned, the EMG was normal except that H-reflexes could not be obtained. Dr. L explained that the "H-reflex requires a motor fiber to the soleus muscle and an appropriate sensory fiber from the sciatic nerve to carry a neuronal message up through the S1 root into the motor pool of the spinal cord at approximately the S1 level." In his three page letter, Dr. L explained that the absence of an H-reflex in a patient can be caused by a number of things, including problems in the sensory input fiber, the cauda equina, the spinal cord, or the motor fiber to the soleus muscle. He said the H-reflex can also be blocked if the patient is tense and unable to relax her muscles. He said the claimant was tense and may have blocked this reflex inadvertently. In addition, Dr. L said that it has been estimated that three to five percent of normal people simply do not have an H-reflex and there is no explanation in those cases. Dr. L said he could not give a firm answer with regard to a question concerning differences in the claimant's diagnostic test results over time.

By letter dated February 2, 1993, the claimant notified the Commission that she desired to change her treating doctor from Dr. R to Dr. G. She stated that she wanted the change because Dr. G had recommended a course of treatment for her besides surgery. The request was approved by the Commission on February 12, 1993.

The claimant testified that her back still hurts her. She said she does not want back surgery because she is too young to have surgery and because she has heard about people who have gotten worse through surgery. She further testified that she changed treating doctors to Dr. G in order to get the epidural steroid injections. As of the date of the hearing, February 18, 1993, the claimant had not had an injection. The claimant further testified that her condition has not gotten any better, rather, it has gotten worse. The claimant agreed that only Dr. R had recommended surgery, and that Drs. G, Q, and SC didn't think she needed surgery.

As previously noted, the issue at the hearing was whether the claimant was owed TIBS in light of the certification of MMI, with a zero percent impairment rating, by Drs. Q and SC. Although Dr. Q's reports were kept out of evidence, the substance of his findings are stated in Dr. SC's report which was in evidence.

Article 8308-4.23(a) provides, in part, that an employee who has disability and who has not attained MMI is entitled to TIBS. Subsection (b) of that article provides that TIBS continue until the employee has reached MMI. Dr. R had issued a series of notes indicating that the claimant was "disabled," and, apparently, no issue as to the claimant's disability as

defined in the 1989 Act was in dispute. Article 8308-1.03(32) defines MMI as the earlier of: (A) the point after which further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated, based on reasonable medical probability; or (B) the expiration of 104 weeks from the date income benefits begin to accrue. It is the first part of the definition of MMI that is applicable to the facts of this case.

Article 8308-4.25(b) provides as follows:

> If a dispute exists as to whether the employee has reached maximum medical improvement, the commission shall direct the employee to be examined by a designated doctor selected by mutual agreement of the parties. If the parties are unable to agree on a designated doctor, the commission shall direct the employee to be examined by a designated doctor selected by the commission. The designated doctor shall report to the commission. The report of the designated doctor shall have presumptive weight, and the commission shall base its determination as to whether the employee has reached maximum medical improvement on that report unless the great weight of the other medical evidence is to the contrary.

Under Article 8308-4.26(g), the report of the designated doctor selected by the Commission concerning the employee's impairment rating has presumptive weight and the Commission must base the impairment rating on that report unless the great weight of the other medical evidence is to the contrary, in which case the Commission shall adopt the impairment rating of one of the other doctors. Evidence of impairment must be based on an objective clinical or laboratory finding. Article 8308-4.25(a). "Objective" means independently verifiable or confirmable results that are based on recognized laboratory or diagnostic tests or signs confirmable by physical examination. Article 8308-1.03(34). It is not unusual to have disagreement or some degree of disparity between the reports of various doctors who have treated or examined the injured worker. *See* Texas Workers' Compensation Commission Appeal No. 93105, decided March 26, 1993, and decisions cited therein. In Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992, we pointed out that it is not just equally balancing evidence or a preponderance of the evidence that can overcome the presumptive weight given the designated doctor's report; rather, such other medical evidence must be determined to be the "great weight" of the medical evidence contrary to the report. Moreover, no other doctor's report, including that of a treating doctor, is accorded the special presumptive weight given to the designated doctor's report. *See* Texas Workers' Compensation Commission Appeal No. 92366, decided September 10, 1992.

The claimant contends that the hearing officer erred in concluding that the claimant reached MMI on March 13, 1992, with a zero percent impairment rating, as reported by the designated doctor, and asserts that the great weight of the medical evidence is contrary to

the report of the designated doctor. Having reviewed the record, we conclude that there is sufficient evidence to support the hearing officer's decision which accorded presumptive weight to the designated doctor's report and found that the great weight of the other medical evidence was not contrary thereto. Basically, there is a difference of medical opinion as to whether the claimant needs further treatment before MMI is reached. Dr. R, the initial treating doctor, believes that the claimant has not reached MMI and that she needs surgery. The claimant does not want surgery. Dr. G certified MMI, does not recommend surgery, but suggests epidural steroid injections. He believes that the claimant has a seven percent impairment rating. Dr. G's subsequent letter to the claimant's attorney could be taken to be somewhat ambiguous on the question of expected results from the injections. However, after discussing the injections, he reiterates that the claimant has reached MMI. Nowhere does he state that the injections will result in further material recovery from or lasting improvement to the claimant's injury. Dr. SC, the designated doctor, certified MMI with a zero percent impairment rating. Dr. SC reviewed the claimant's test results, including the discogram. He did not give the discogram much weight in light of other test results and his own physical and neurological examination of the claimant. Dr. SC specifically opined that neither surgery nor further treatment is indicated. Although Dr. Q's reports are not in evidence, it is evident from Dr. SC's review of medical reports that Dr. Q examined the claimant and reached the same conclusions as Dr. SC. They both determined that there was no objective findings to substantiate the claimant's continued subjective complaints and that she had no evidence of permanent impairment. Dr. L's opinion on the absence of H-reflexes is inconclusive. Given the difference of medical opinion, and the fact that Dr. SC, the designated doctor, is not alone in his findings concerning no objective evidence to substantiate continued subjective complaints and no permanent impairment, we cannot conclude that the hearing officer erred in giving presumptive weight to the designated doctor's report and in finding that the great weight of the other medical evidence was not contrary to that report.

The claimant further contends that the hearing officer erred in finding that the claimant reached MMI on March 13, 1992, as reported by the designated doctor, because the designated doctor did not examine the claimant until October 15, 1992. In Texas Workers' Compensation Commission Appeal No. 92453, decided October 12, 1992, we affirmed a hearing officer's decision which gave presumptive weight to the report of the designated doctor where the designated doctor certified that the claimant had reached MMI some four months before the date of examination by the designated doctor. In that case we stated "We do not find in the MMI provisions of the 1989 Act or in the Commission's rules, any provision which specifically restricts the designated doctor to certifying MMI only as of the date of his or her examination of the employee." *See also* Texas Workers' Compensation Commission Appeal No. 92336, decided August 31, 1992, where we stated that "Nothing in the statute or the rules, Texas W.C. Comm'n, 28 TEX. ADMIN. CODE Sections 130.1 and 130.5, appears to prohibit a doctor from determining that the point of MMI occurred sometime in the past." In the instant case it is clear from the report of Dr. R, the initial

treating doctor, that Dr. Q examined the claimant on March 13, 1992, and it is equally clear from the report of Dr. SC, the designated doctor, that Dr. Q, on the date of examination, found no objective evidence to substantiate the claimant's complaints and no impairment. Some seven months later, Dr. SC made the same findings as had Dr. Q on March 13, 1992. Thus, Dr. SC had a factual basis for determining that the claimant had reached MMI on March 13, 1992. Accordingly, we do not find merit in the claimant's contention concerning the date of MMI.

The claimant also contends that the hearing officer erred in giving presumptive weight to Dr. SC's report because there was no evidence that the claimant was given ten days to agree with the insurance carrier on a designated doctor nor that the claimant, who was unrepresented at the BRC but was represented at the hearing, received an explanation of the significance of the term "designated doctor." Rule 130.6(b) provides that after notifying the employee and the insurance carrier [that a designated doctor will be directed to examine the employee] the commission shall allow the employee and insurance carrier ten days to agree on a designated doctor, and further provides that the commission shall inform an unrepresented employee that an ombudsman is available to explain the contents of the agreement for a designated doctor. Since neither of these points were raised in the prior proceedings, they will not be determined for the first time on appeal. *See* Texas Workers' Compensation Commission Appeal No. 91100, decided January 22, 1992. *Compare* Texas Workers' Compensation Commission Appeal No. 93099, decided March 25, 1993, where we affirmed the hearing officer's decision that a doctor that had determined MMI was not a designated doctor because the Commission had failed to comply with the ten day requirement for allowing the parties to agree on a designated doctor as set forth in Rule 130.6; however, in that case the claimant contended at the hearing that the doctor was not a designated doctor on the basis that he was not given any opportunity to agree on a designated doctor prior to selection of a designated doctor by the Commission. In the instant case, the only reference to the designated doctor by the claimant's attorney which could arguably be considered an attack on the status of the designated doctor was the following exchange between the claimant's attorney and the hearing officer during closing argument:

Claimant's attorney: By the way, the mention of the designated doctor, we do not have any statutory designated doctor of a statutory sense. We do not have any presumptions here from this record as to their findings. We first see the - -

Hearing Officer: Just to be sure that I'm clear, are you saying that [Dr. SC] is not the designated doctor.

Claimant's attorney: She was instructed to see [Dr. SC].

Hearing Officer: By the Commission.

Claimant's attorney: But she agreed to do it. There was no actual requirement of an order, I believe. She agreed to do this.

Considering the fact that the claimant's attorney gave a nonresponsive answer to the hearing officer's question regarding Dr. SC's status as the designated doctor, we can find no basis on appeal for finding in the record any indication that noncompliance with Rule 130.6 was put into issue by the claimant at the hearing. In the BRC report and at the hearing Dr. SC was referred to as the designated doctor without comment or objection by the claimant. We believe that under the facts presented in this case it is too late to wait until the appeal to attack Dr. SC's status as the designated doctor.

Most of the remainder of the claimant's contentions involve its request to add an issue at the hearing. The claimant requested that the hearing officer add an issue to the effect that in computing average weekly wage (AWW) for the purpose of calculating TIBS, the carrier failed to include the market value of lodging provided to the claimant by the employer. The carrier objected to the addition of this issue. The hearing officer sustained the carrier's objection, but then said he would continue the hearing to March 29, 1993, at which time he would hear evidence on the AWW issue. However, the hearing officer indicated that if the parties were to enter into an agreement concerning the AWW issue, there would be no need for the March 29th hearing. In the Statement of the Case portion of the decision, the hearing officer states: "The parties reached an agreement about the issue of the average weekly wage and it will not be addressed in this decision and order." The claimant acknowledges in its appeal that an agreement concerning AWW was made and attaches to its appeal a copy of the hearing officer's order cancelling the March 29th hearing due to the parties agreement on AWW and attaches a copy of the purported agreement. The agreement provides that the claimant's AWW is $298.96, that this amount reflects an increase of $30.40 which is the value of housing provided to the claimant by her employer; that the carrier will adjust the claimant's AWW accordingly and add applicable interest and forward the claimant additional benefits due her, if any. In its response, the carrier also acknowledges that an agreement on AWW was made prior to the scheduled hearing on March 29th, and states that in view of that agreement, there was nothing for the hearing officer to decide in reference to AWW.

We disagree with the claimant's contention that the hearing officer erred in determining not to address the party's agreement on AWW in his Decision and Order. The agreement, which both parties admit was entered into and neither party seeks to vacate, modify, or otherwise attack as being invalid for any reason whatsoever, resolved the dispute over whether AWW would include the value of the lodging provided to the claimant by the employer. Thus, there was nothing to be determined by the hearing officer in regard to the issue which the claimant wanted to have added at the hearing. It appears clear from the

appeal and response that the parties intend to comply with the agreement in all respects. Computing the amount of additional TIBS, if any, due the claimant because of the increase in AWW for the period she had disability prior to reaching MMI on March 13, 1992, is a matter of applying the provisions of Article 8308-4.23 and applicable Commission rules which we understand the carrier has agreed to do per the terms of the agreement. While it would have been better if the hearing officer had put the parties' agreement into the record, his failure to do so in the face of the parties' representation that the agreement was made, does not constitute a basis for disturbing his decision.

We likewise do not find merit in the claimant's contention that the hearing officer erred in determining that the claimant is not eligible for any income benefits for any time period after she reached MMI. That is a correct application of the law as applied to the facts of this case. The claimant is not entitled to TIBS after reaching MMI on March 13, 1992, and her zero percent impairment rating precludes her from receiving impairment income benefits and supplemental income benefits. Articles 8308-4.23(b); 8308-4.26; 8308-4.28. Additional TIBS due the claimant, if any, due to the increase in AWW would apply to the time period in which she was entitled to TIBS; that being the period when she had disability and had not reached MMI. Article 8308-4.23(a).

We also do not find merit in the claimant's assertion that the provisions of Article 8308-4.16(e), Rule 126.6(e), and Rule 130.4(d) somehow act to preclude the hearing officer from determining that income benefits are not due for the time period after the claimant reached MMI. Article 8308-4.16(e) and Rule 126.6(e) pertain to holding a BRC after a medical examination order doctor releases an employee to return to work. A release to return to work by an MEO doctor was simply not an issue in this case. Rule 130.4 pertains to procedures that an insurance carrier may follow when there has not been a certification of MMI, and Subsection (d) of that Rule prohibits suspension of TIBS based on Rule 130.4 unless a benefit review officer issues an interlocutory order granting such suspension. Clearly, Rule 130.4 is not applicable to the facts of this case since at least two doctors certified MMI.

Lastly, the claimant asserts that the carrier did not comply with Rule 124.4 (Notice of Reduction or Termination of Compensation) or Rule 124.6 (Notice of Refused or Disputed Claim). While not deciding the applicability of the cited rules to the issue before the hearing officer for resolution, we simply note that no issue relating to the cited rules was raised at the BRC or brought before the hearing officer and thus the claimant's assertion concerning those rules will not be decided for the first time on appeal. Appeal No. 91100, *supra*.

The decision of the hearing officer is affirmed.

Robert W. Potts
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Philip F. O'Neill
Appeals Judge